MDR Tracking Number: M5-04-0301-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 09-29-03.

The IRO reviewed hot or cold pack therapy, therapeutic exercises and office visit rendered from 10-22-02 through 04-14-03 that was denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 12-04-03, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
10-25-02	97010	$15.00	$0.00	F	$11.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of $11.00
10-25-02	97110	$120.00 (3 units)	$0.00	F	$35.00	Rule 133.307 (g)(3)(A-F)	See rationale below. No reimbursement recommended.
4-14-03	99080-73	$20.00	$0.00	F	DOP	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service.

							Reimbursement recommended in the amount of $20.00
TOTAL		$155.00	$0.00		$46.00		The requestor is entitled to reimbursement in the amount of $31.00

RATIONALE: Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one". Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division (MRD) has reviewed the matters in light of the Commission requirements for proper documentation.

The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 8-28-01 through 12-28-01 in this dispute.

This Findings and Decision and Order is hereby issued this 12th day of March 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

March 3,2004

NOTICE OF INDEPENDENT REVIEW DECISION
Amended Determination B

RE: MDR Tracking #: M5-04-0301-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 44 year-old female who sustained a work related injury on ___. The patient reported that while at work she was rotating stock that involved lifting boxes weighing approximately 30lbs. The patient reported that while doing this she experienced a "pop" sensation in her back. The patient underwent X-Rays of the thoracic spine on 7/29/02. The patient was also referred for an MRI and underwent an EMG/NCV. The diagnoses for this patient include mechanical lower back pain without radiculopathy. Treatment for this patient's condition has included physical therapy, occupational therapy, chiropractic care, biofeedback, oral medications, injections and a work-hardening program.

Requested Services

Hot or cold pack therapy, therapeutic exercises, office visit, from 10/22/02 through 4/14/03.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is partially overturned.

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a 44 year-old female who sustained a work related injury to her back on ___. The ___ chiropractor reviewer also noted that the diagnosis for this patient have included mechanical lower back pain without radiculopathy. The ___ chiropractor reviewer further noted that treatment for this patient's condition included physical therapy, occupational therapy, chiropractic care, biofeedback, oral medications, injections and a work hardening program. The ___ chiropractor reviewer explained that the patient was still under an active therapy program on 10/22/02 and 11/5/02. The ___ chiropractor reviewer indicated that these visits were in the middle of active therapy. The ___ chiropractor reviewer explained that the office visit for 4/14/03 was necessary for evaluation purposes. Therefore, the ___ chiropractor consultant concluded that the ice and cold therapy, therapeutic exercises on 10/22/02, 11/5/802 and the office visit on 4/14/03 were medically necessary to treat this patient's condition.

Sincerely,